

PLACE OF DEATH

County Jasper

Township _____

or

Village _____

or

City Joplin, Mo. (NO Castle Rock Addition)MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHRegistration District No. 411File No. 8900Primary Registration District No. 2002Registered No. 148

Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Virgil Thomas Gibbs

PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

COLOR OR RACE

WhiteSINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)Single

DATE OF BIRTH

January 4, 1895
(Month) (Day) (Year)

AGE

19 yrs. 2 mos. 22 ds.If LESS than
1 day, ____ hrs.
or ____ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work

Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

Grocery

BIRTHPLACE

(City or town, State or foreign country)

Mo.

PARENTS

NAME OF FATHER

John R. Gibbs

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Santa Fe, Mo.

MAIDEN NAME OF MOTHER

Ira McClellan

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Pike Co., Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John R. Gibbs

(ADDRESS)

Joplin, Mo.

Filed

3-28, 1914ANDREY

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Mar. 26, 1914
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Mar 26, 1914, to Mar 24, 1914, that I last saw him alive on Mar 24, 1914, and that death occurred, on the date stated above, at 11:25 a.m. The CAUSE OF DEATH* was as follows:1228 Locked Bowel(Duration) ____ yrs. ____ mos. 2 ds.

Contributory

(SECONDARY)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed)

J. Hines

M. D.

Mar 27, 1914(Address) Joplin, Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

Mount Hope

DATE OF BURIAL

Mar. 29, 1914

UNDERTAKER

Frank-Servos

ADDRESS

Joplin, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc. of (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

PLACE OF DEATH

County

Township

Village

City

Registration District No.

File No.

Primary Registration District No.

Registered No.

(No.)

St.

Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF DEATH

DATE OF BIRTH

AGE

If LESS than
1 day, hrs.
or min.

OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE

(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

REGISTRAR

I HEREBY CERTIFY, that I attended deceased from

Satisfactory Information Supplied.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Broken Bowls
Dr. stated he didn't know cause
in there want any operation.

Contributory

(SECONDARY)

(Signed)

2/27 1914 (Address)

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LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death, mos. ds. In the State, yrs. mos. ds.

Where was disease contracted

If not at place of death

Former or usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

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[Approved by U. S. Census and American Public Health
Association]

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8900

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